Whistleblowing in the NHS

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Patient-Centred Care

Whistleblowing in the NHS-Freedom to speak up: a summary

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Abstract: Health Professionals have a duty of care to raise a concern if they believe a patient is at risk of harm. However, these interventions are not always welcomed by authorities. Sir Robert Francis' review, "Freedom to Speak Up", published in 2015, was designed to address the reporting culture in the NHS. A symposium, "Freedom to Speak Out," held at the Royal College of Physicians and Surgeons in Glasgow in September 2016, considered various aspects of whistleblowing. This article discusses the issues raised and provides advice for people raising concerns. It concludes with some reflections on Sir Robert's review.

Clinical Relevance: Dentists and Dental Care Professionals need to be aware of their duty of care to raise concerns when patient safety is at risk and how to go about it.

Objectives: The reader should have an understanding of the issues surrounding whistleblowing and how to go about raising a concern.

Whistleblowing in the NHS-Freedom to speak up: a summary

Introduction

Whistleblowers have played a pivotal role in exposing poor patient care and its often tragic consequence within the NHS.[1,2] Despite this courageous and ethical behaviour, these people have generally been poorly treated by their organisations. Their legitimate concerns have often been ignored and they have sometimes been subjected to scapegoating, isolation, suspension and coercion into signing gagging agreements. For some, the consequences have been catastrophic both professionally and personally.[3]

After an intensive lobbying campaign, Secretary of State for Health, Jeremy Hunt, asked Sir Robert Francis QC, to carry out an independent review into the reporting culture within the NHS. Sir Robert considered evidence from 43 organisations and 600 individuals as well as surveying over 19,500 staff before coming up with a raft of measures to affect a transformation within the NHS. "Freedom to Speak Up (FTSU) – A review of whistleblowing in the NHS," was published in February 2015.[3] The five key themes in his 223 page review were the need for:

- Culture change
- Improved handling of cases
- Measures to support good practice
- Particular measures for vulnerable groups
- Extending legal protection

Hard on the heels of the "Speak Up" review came Sir Anthony Hooper's report on "The Handling by the GMC of cases involving whistleblowers."[4] This addressed the practice employed by some trusts of vexatious referral of whistleblowers to the GMC. An extreme example of this was cardiologist, Dr Raj Mattu, referred to the GMC by his Trust for 200 alleged misdemeanours, none of which was upheld. Hooper made several recommendations to remedy this situation, the first two of which were that organisations referring a doctor's fitness to practice to the GMC should state whether that doctor had raised concerns about patient safety or the integrity of the system and secondly that when a doctor's fitness to practice was referred to the GMC by an organisation the allegations in the document had to be verified by a registered doctor.

Freedom to Speak Out Symposium

A symposium, Freedom to Speak Out, was held at the Royal College of Physicians and Surgeons in Glasgow (RCPSG) in September 2016 to discuss what progress, if any, had been made in the 18 months since the FTSU review was published (the symposium, which can be seen online, has been divided into four elearning modules available on the RCPSG website).[5] Key players from both sides of the border shared their expertise in different aspects of whistleblowing with an interested audience.

What is whistleblowing?

Cathy James, OBE, chief executive at the whistleblowing charity, Public Concern at work (PCaW),[6] provided her definition as **"a worker raising a concern about wrong doing, risk or**

malpractice with someone in authority, either internally and/or externally (i.e. regulators, media, MPs,).” She pointed out the difference between whistleblowing and raising a grievance. **A grievance involves a risk to oneself and does not impact on the wider public whereas a concern involves a risk to others. Whistleblowing is always about raising concerns.**

Ms James detailed the workings and recent changes to the Public Interest Disclosure Act 1998 (PIDA),[7]the law designed to protect whistleblowers from detriment. Norman Provan, Associate Director of the Royal College of Nursing in Scotland, sought to draw a distinction between whistleblowers, whose actions are protected by the strict criteria of PIDA, and the much more common case of people simply raising a concern with the desire to see remedy or positive change.

A common theme throughout the day was the **duty of staff to raise a concern if they believe there is a risk to patient safety or public protection and that this duty overrides personal and professional loyalties. There is no need to wait for proof – one can justify raising a concern if one does so honestly, on the basis of reasonable belief and through appropriate channels, even if one is mistaken.**

Rise of the Managerial Culture

Andrew Bousfield, barrister and award winning investigative journalist with a special interest in whistleblowing, was outspoken on the rise of the managerial culture in the NHS and was scathing about a system where senior managers who have singularly failed in a particular post can move seamlessly sideways or even upwards, reputation in tatters but income intact. The point was made throughout the day that unlike clinical staff who are all subject to regulation,

there is no regulatory body to monitor the behaviour of managers. Bousfield cited an example of management malpractice when he described how Trust managers in Mid Staffs grossly exaggerated the number of patients whose care was simply palliative, thereby lowering the number of avoidable deaths (Paul Taylor's article, "Rigging the Death Rate", is an excellent exposition of the statistical story behind the Bristol and Mid Staffs scandals).[8]

Norman Provan, speaking with a wealth of experience in NHS Scotland, warned against a simplistic mindset that whistleblowing is always doomed to fail. Even in those organisations which leave something to be desired, microcultures of good practice do exist.

Impact on Whistleblowers

Mr Nick Renny, Consultant in Oral and Maxillofacial Surgery, described in detail some of the tactics used against NHS whistleblowers and the resulting consequences.[3,9]These ranged from subtle actions like whispering campaigns and impugning reputations to more aggressive reprisals like isolation, suspension and vexatious/retaliatory referral to regulatory bodies. In house investigations can be biased and dragged out and the whistleblower is usually kept in the dark of developments. External inquiries set up by hospitals can choose who investigates the complaint, set very limited terms of reference, withhold or redact information and in the unlikely event of an unfavourable conclusion, prevent dissemination of the report because they own it. Although gagging clauses where there is a public interest are now illegal, trusts can still resort to strict confidentiality agreements to silence whistleblowers. The consequences for the whistleblower are often stress related illness, family disruption and great difficulty in resuming employment.

Meanwhile the original concern remains ignored, unanswered or discredited, often to the detriment of patients.

The Whistleblower's Tale

Dr Kim Holt, a highly regarded paediatrician, has personal experience of some of the tactics outlined above.[9] She gave an account of the failure of management in Haringey Primary Care Trust and Great Ormond Street Hospital (GOSH) Trust to act on a number of concerns that led to the tragic death of the toddler, Peter Connolly, known in the press at the time as "Baby P". The workload, which was onerous when she took up the post, became unsustainable when a post was cut and a colleague resigned. When she raised concerns that this, as well as severe major systemic failings in the department were jeopardising children's safety, she was isolated, verbally abused by a manager and then referred without her knowledge to Occupational Health with "mental health" issues. It was while she was on special leave that important signs that could possibly have saved the boy's life were missed. The GOSH Trust then set about burying any evidence of a failing department. Dr Holt was offered increasing financial inducements to sign a non-disparagement agreement and resign her post, something she refused to do. After a prolonged stand-off, she eventually received an apology from Haringey and GOSH. Fortunately, her department was transferred to another trust and she was able to resume her career.

Changing the Culture

Two senior Scottish lawyers tried to get to the bottom of a defective culture that allowed Kim Holt and others like her to be victimised for raising legitimate concerns. Alan Paterson OBE,

Professor of Law at Strathclyde University, shared some of the findings from the 2015 review that he chaired, "Learning from Serious Failings in Care."[10]The review revealed a common thread running through reports on failing hospitals. Poor senior leadership both clinical and managerial and a silo mentality with little communication between the two sides was a common theme. Staff shortages and insufficient skills mix or experience often led to poor morale, an acceptance of poor standards and a feeling of "learned helplessness." He advocated a greater involvement of medical staff in senior NHS management and that all stakeholders should cooperate to improve NHS working culture and address "learned helplessness" and bullying in the workplace.

Robert Carr outlined the maelstrom of challenges confronting the modern Health Service, health professionals and the legal landscape where the traditional paradigm of doctor/patient relationship has ceased to reflect reality. He quoted the 2011 McClean report[11] that there needs to be a willingness to discuss adverse incidents in order to enable learning.

For this to happen a culture of candour, openness and honesty is essential, something that has been called for by numerous inquiries into NHS failure over the years. Professor Craig White, a Scottish Government Clinical Lead described how he was part of the team that saw a bill for a "Duty of Candour" for health and social care organisations in Scotland, enshrined in law in 2016.[12]

Raising a Concern

Perhaps the most important piece of advice for anyone contemplating raising a concern is: **seek advice before you do so.** A number of organisations such as "NHS Whistleblowing Helpline,[13]

Patients First[14](founded by Kim Holt) and PCaW[6] offer support and advice to whistleblowers. At PCaW the likelihood of a positive outcome for the concern (investigated, admitted, resolved) increases by 26% and a favourable personal outcome doubles, if advice is sought prior to raising a concern.[15] Dr Holt emphasised the important role that professional psychological support can play in these extremely stressful cases.

Meticulous documentation of all matters relating to the concern including conversations is essential. Dr Peter Mackenzie, Senior Medicolegal Advisor spoke about the need for good faith, honesty, objectivity and professionalism when raising a concern. "Let the facts speak for themselves," was his sound advice.

The Dentist as Whistleblower

Raising a concern in a general dental practice poses its own challenges due to shared professional roles, financial interdependency and close personal relationships in a more intimate setting than a hospital.

The GDC has a robust policy on raising concerns. In "Standards for the Dental Team", the document that sets out the standards of conduct, performance and ethics for dental professionals, Principle 8 is devoted entirely to raising concerns.[16] There is also detailed advice on the GDC website about raising a concern as well as how best to investigate it, once it has been raised.

A free, confidential helpline for dentists wishing to raise concerns was set up in September 2015 by the GDC. It is run by PCaW. All advisors are trained in the legal issues that surround raising concerns and are supervised by lawyers. The information is legally privileged and is not passed

on to the GDC. During its first year, PCaW received 157 calls to the GDC Freephone number and 46 were defined as having a public concern element. Callers were advised how best to raise their concern locally at first, with escalation steps, including to the GDC, as a last resort. Follow up calls are made by PCaW to each caller to discuss the outcome, provide additional support and assess whether there are any remaining public concerns.

NHS England has also recently published guidance for primary care workers like dentists who want to raise a concern.[17] Dentists and Dental Care Professionals are advised to familiarise themselves with these guidelines as well as the advice on the GDC website.

Some Reflections on Freedom to Speak Up Guardians

One of the key recommendations in the Francis review was the appointment of FTSU guardians within every organisation.[3] Their role is to increase awareness about raising concerns in the organisation, act as a first port of call for people raising concerns and support them through this stressful process. Guardians, while they can report directly to chief executives have limited powers. They have no powers to investigate concerns. It is essentially a "soft" role. In October 2016, a National FTSU guardian took up office to oversee the local guardians throughout England. She is nominally independent but sponsored by the Care Quality Commission (CQC), NHS England and NHS Improvement. She has no statutory powers. There are plans for Scotland to implement a similar scheme with non-executive whistleblowing champions for every Health Board supervised by an Independent National Officer.[18]The Francis recommendations do not apply to Wales[19] and Northern Ireland[20] which have their own arrangements for raising concerns.

Andrew Bousfield and Kim Holt who had given evidence to the FTSU inquiry had major reservations about the Francis review because they felt his recommendations lacked teeth. These criticisms were encapsulated in a letter to the Times in February 2016 from high profile whistleblowers.[21]In his presentation, Bousfield called for an independent whistleblowing inspectorate, manned by doctors with statutory powers to investigate concerns, an idea rejected by Sir Robert.

Although the guardian scheme is in its infancy contact was made with two local guardians to see how they were adapting to the role. They were highly regarded clinicians, intelligent, dynamic and completely committed to a culture of openness in the NHS. Resilient too, because local guardians get trolled mercilessly on social media by those implacably opposed to the scheme. They were long time employees in the Health Service and familiar with the workings and politics of the NHS. Those contacted felt that because they combine their guardian role with their clinical duties (something often attacked by FTSU critics), staff know that they are confiding in someone also at the frontline of health care and see that as a positive attribute. These guardians had already carried out a number of initiatives to raise staff awareness of FTSU. It was notable that they had a good relationship with their non-executive directors responsible for raising concerns and also with their chief executives. In well run trusts with stable, enlightened leadership, the guardians can and probably will make a positive difference.

The problem is that unlike the Scottish model, where policy is decided by NHS Scotland and passed down to Health Boards throughout the country, in England there are over two hundred Trusts, of which 150 are Foundation Trusts with their own bureaucracy, budgets, policies and

cultures. This applies to local guardians as well. There is no uniformity as to how these people are appointed, the working hours, remuneration and most importantly, who occupies the role.

A number of trusts have appointed non-executive directors or other people on the management side as FTSU guardians. Rightly or wrongly, the vast majority of whistleblowers see managers as part of the problem. The idea that that they will be the first port of call for people raising concerns seems misguided to say the least. Also the continuity of support that FTSU guardians rely on to succeed in the role will be missing in those poorly run trusts, some in "special measures," where there is a high turnover of senior management.

So what does the future hold? The piloting of some of Hooper's recommendations by the GMC since June 2016 and the robust measures put in place by the GDC are positive signs. However, the publication by the CQC, almost two years post Francis, of a review into how deaths are investigated and bereaved relatives treated, showed multiple failings across the NHS.[22] The happy day when whistleblowing will no longer be necessary would seem to be a long way off.

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